House Amendment to
Senate File 2201

S-5335

Amend Senate File 2201, as amended, passed, and reprinted by the Senate, as follows:

1. Page 2, after line 29 by inserting:

<Sec. ___. Section 505.7, Code Supplement 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 10. *a.* The commissioner shall assess the costs of carrying out the insurance division's duties pursuant to section 505.8, subsection 18, section 505.17, subsection 2, and sections 505.18 and 505.19 that are directly attributable to the performance of the division's duties involving specific health insurance carriers licensed to do business in this state. Such expenses shall be charged to and paid by the specific health insurance carrier to whom the expenses are attributable and upon failure or refusal of any such carrier to pay such expenses, the same may be recovered in an action brought in the name of the state. In addition, the commissioner may revoke the certificate of authority of a health insurance carrier licensed to do business in this state that fails to pay such expenses attributable to that carrier.

b. The commissioner shall assess the costs of carrying out the insurance division's duties generally pursuant to section 505.8, subsection 18, section 505.17, subsection 2, and sections 505.18 and 505.19, and for implementation and maintenance of health insurance information for consumers on the insurance division internet site, that are not attributable to a specific health insurance carrier, to all health insurance carriers that are licensed to do business in this state on a proportionate basis as provided by rules adopted by the commissioner.

Sec. ___. Section 505.8, Code Supplement 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 18. The commissioner shall annually convene a work group composed of the consumer advocate, health insurance carriers, health care providers, small employers that purchase health insurance under chapter 513B, and individual consumers in the state for the purpose of considering ways to reduce the cost of providing health insurance coverage and health care services, including but not limited to utilization of uniform billing codes, improvements to provider credentialing procedures, reducing out-of-state care expenses, annually assessing the impact of federal health care reform legislation on health care costs in the state and determining whether such legislation has reduced the cost of health insurance in the state, and the electronic delivery of explanation of benefits statements. The

recommendations made by the work group shall be included in the annual report filed with the general assembly pursuant to section 505.18.

Sec. ___. Section 505.17, Code 2009, is amended to read as follows:

505.17 Confidential information.

1. *a.* Information, records, and documents utilized for the purpose of, or in the course of, investigation, regulation, or examination of an insurance company or insurance holding company, received by the division from some other governmental entity which treats such information, records, and documents as confidential, are confidential and shall not be disclosed by the division and are not subject to subpoena. Such information, records, and documents do not constitute a public record under chapter 22.

b. The disclosure of confidential information, administrative or judicial orders which contain confidential information, or information regarding other action of the division which is not a public record subject to disclosure, to other insurance and financial regulatory officials may be permitted by the commissioner provided that those officials are subject to, or agree to comply with, standards of confidentiality comparable to those imposed on the commissioner.

2. Notwithstanding subsection 1, an application for a rate increase filed by a health insurance carrier and all information, records, and documents accompanying such an application or utilized for the purpose of, or in the course of consideration of the application by the commissioner, shall constitute a public record under chapter 22 except as provided in this subsection.

a. The commissioner shall consider the written request of a health insurance carrier to keep confidential certain details of an application or accompanying information, records, and documents. If the request includes a sufficient explanation as to why public disclosure of such details would give an unfair advantage to competitors, the commissioner shall keep such details confidential. If the commissioner elects to keep certain details confidential, the commissioner shall release only the nonconfidential details in response to a request for records made pursuant to chapter 22. If confidential details are withheld from a request for records made pursuant to chapter 22, the commissioner shall release an explanation of why the information was deemed confidential and a summary of the nature of the information withheld and the reasons for withholding the information.

b. In considering requests for confidential treatment, the commissioner shall narrowly construe the provisions of this subsection in order to appropriately balance an applicant's need for confidentiality against the public's right to information about the application.

c. The commissioner shall adopt rules establishing a process relating to requests to keep information confidential pursuant to this subsection which may include but are not limited to the following:

(1) The nature and extent of competition in the applicant's industry sector or service territory.

(2) The likelihood of adverse financial impact to the applicant if the information were to be released.

(3) Any other factor the commissioner reasonably considers relevant.

Sec. ___. NEW SECTION. **505.18 Annual report.**

1. Consumers deserve to know the quality and cost of their health care insurance. Health care insurance transparency provides consumers with the information necessary, and the incentive, to choose health plans based on cost and quality. Reliable cost and quality information about health care insurance empowers consumer choice and consumer choice creates incentives at all levels, and motivates the entire health care delivery system to provide better health care and health care benefits at a lower cost. It is the purpose of this section to make information regarding the costs of health care insurance readily available to consumers through the consumer advocate bureau of the insurance division.

2. The commissioner in collaboration with the consumer advocate shall prepare and deliver a report to the governor and to the general assembly no later than November 15 of each year that provides findings regarding health spending costs for health insurance plans in the state for the previous fiscal year. The commissioner may contract with outside vendors or entities to assist in providing the information contained in the annual report. The report shall provide, at a minimum, the following information:

a. Aggregate health insurance data concerning loss ratios of health insurance carriers licensed to do business in the state.

b. Rate increase data.

c. Health care expenditures in the state and the effect of such expenditures on health insurance premium rates.

d. A ranking and quantification of those factors that result in higher costs and those factors that

result in lower costs for each health insurance plan offered in the state.

e. The current capital and surplus and reserve amounts held in reserve by each health insurance carrier licensed to do business in the state.

f. A listing of any apparent medical trends affecting health insurance costs in the state.

g. Any additional data or analysis deemed appropriate by the commissioner to provide the general assembly with pertinent health insurance cost information.

h. Recommendations made by the work group convened pursuant to section 505.8, subsection 18.

Sec. ___. NEW SECTION. **505.19 Health insurance rate increase applications — public hearing and comment.**

1. All health insurance carriers licensed to do business in the state shall immediately notify policyholders of any application for a rate increase exceeding the average annual health spending growth rate stated in the most recent national health expenditure projection published by the centers for Medicare and Medicaid services of the United States department of health and human services, that is filed with the insurance division. Such notice shall specify the rate increase proposed that is applicable to each policyholder and shall include the ranking and quantitification of those factors that are responsible for the amount of the rate increase proposed. The notice shall include information about how the policy holder can contact the consumer advocate for assistance.

2. The commissioner shall hold a public hearing at the time a carrier files for proposed health insurance rate increases exceeding the average annual health spending growth rate as provided in subsection 1, prior to approval or disapproval of the proposed rate increases for that carrier by the commissioner.

3. The consumer advocate shall solicit public comments on each proposed health insurance rate increase application if the increase exceeds the average annual health spending growth rate as provided in subsection 1, and shall post without delay all comments received on the insurance division's internet site prior to approval or disapproval of the proposed rate increase by the commissioner.

4. The consumer advocate shall present the public testimony and comments received for consideration by the commissioner in determining whether to approve or disapprove such health insurance rate increase

proposals.

4A. *a.* For the purposes of this section, *"health insurance"* does not include any of the following:

(1) Coverage for accident-only, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical-payment insurance.

(6) Credit-only insurance.

(7) Coverage for on-site medical clinic care.

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

b. For the purposes of this section, *"health insurance"* does not include benefits provided under a separate policy as follows:

(1) Limited scope dental or vision benefits.

(2) Benefits for long-term care, nursing home care, home health care, or community-based care.

(3) Any other similar limited benefits as provided by rule of the commissioner.

c. For the purposes of this section, *"health insurance"* does not include benefits offered as independent noncoordinated benefits as follows:

(1) Coverage only for a specified disease or illness.

(2) A hospital indemnity or other fixed indemnity insurance.

d. For the purposes of this section, *"health insurance"* does not include Medicare supplemental health insurance as defined under § 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided to coverage under group health insurance coverage.

5. The commissioner shall adopt rules pursuant to chapter 17A to implement the provisions of this section.>

2. Page 11, after line 9, by inserting:

<Sec. ___. NEW SECTION. **514C.26 Mental illness and substance abuse treatment coverage for veterans.**

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a group policy or contract providing for third-party payment or prepayment of health or medical expenses issued by a carrier, as defined in section 513B.2, or by an

organized delivery system authorized under 1993 Iowa Acts, chapter 158, shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse if either of the following is satisfied:

a. The policy or contract is issued to an employer who on at least fifty percent of the employer's working days during the preceding calendar year employed more than fifty full-time equivalent employees. In determining the number of full-time equivalent employees of an employer, employers who are affiliated or who are able to file a consolidated tax return for purposes of state taxation shall be considered one employer.

b. The policy or contract is issued to a small employer as defined in section 513B.2, and such policy or contract provides coverage benefits for the treatment of mental illness and substance abuse.

2. Notwithstanding the uniformity of treatment requirements of section 514C.6, a plan established pursuant to chapter 509A for public employees shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse as defined in subsection 3.

3. For purposes of this section:

a. *"Mental illness"* means mental disorders as defined by the commissioner by rule.

b. *"Substance abuse"* means a pattern of pathological use of alcohol or a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when the alcohol or drug is withdrawn.

c. *"Veteran"* means the same as defined in section 35.1.

4. The commissioner, by rule, shall define *"mental illness"* consistent with definitions provided in the most recent edition of the American psychiatric association's diagnostic and statistical manual of mental disorders, as the definitions may be amended from time to time. The commissioner may adopt the definitions provided in such manual by reference.

5. This section shall not apply to accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance,

or automobile medical payment insurance, or individual accident and sickness policies issued to individuals or to individual members of a member association.

6. A carrier, organized delivery system, or plan established pursuant to chapter 509A may manage the benefits provided through common methods including but not limited to providing payment of benefits or providing care and treatment under a capitated payment system, prospective reimbursement rate system, utilization control system, incentive system for the use of least restrictive and least costly levels of care, a preferred provider contract limiting choice of specific providers, or any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

7. *a.* A group policy or contract or plan covered under this section shall not impose an aggregate annual or lifetime limit on mental illness or substance abuse coverage benefits unless the policy or contract or plan imposes an aggregate annual or lifetime limit on substantially all medical and surgical coverage benefits.

b. A group policy or contract or plan covered under this section that imposes an aggregate annual or lifetime limit on substantially all medical and surgical coverage benefits shall not impose an aggregate annual or lifetime limit on mental illness or substance abuse coverage benefits which is less than the aggregate annual or lifetime limit imposed on substantially all medical and surgical coverage benefits.

8. A group policy or contract or plan covered under this section shall at a minimum allow for thirty inpatient days and fifty-two outpatient visits annually. The policy or contract or plan may also include deductibles, coinsurance, or copayments, provided the amounts and extent of such deductibles, coinsurance, or copayments applicable to other medical or surgical services coverage under the policy or contract or plan are the same. It is not a violation of this section if the policy or contract or plan excludes entirely from coverage benefits for the cost of providing the following:

a. Care that is substantially custodial in nature.

b. Services and supplies that are not medically necessary or clinically appropriate.

c. Experimental treatments.

9. This section applies to third-party payment provider policies or contracts and plans established pursuant to chapter 509A delivered, issued for

delivery, continued, or renewed in this state on or after January 1, 2011.>

3. Page 16, by striking lines 9 through 27.

4. Page 18, after line 31 by inserting:

<Sec. ___. 2009 Iowa Acts, chapter 118, section 1, is amended by adding the following new subsection:

NEW SUBSECTION. 6A. The commission shall also complete an annual review of the cost of health insurance mandates currently imposed on health insurance regulated by the state and provide projections of the cost of any mandates that the commission determines may be considered by the general assembly during the upcoming legislative session. The review and projections shall be included in the annual reports provided by the commission to the general assembly pursuant to this section.

Sec. ___. EFFECTIVE UPON ENACTMENT. The following provisions of this Act, being deemed of immediate importance, take effect upon enactment:

1. The section of this Act enacting section 505.7, subsection 10.

2. The section of this Act enacting section 505.8, subsection 18.

3. The section of this Act amending section 505.17.

4. The sections of this Act enacting sections 505.18 and 505.19.

5. The section of this Act amending 2009 Iowa Acts, chapter 118, section 1.

5. Title page, line 4, after <Act,> by inserting <a health care and insurance cost work group, applications for health insurance rate increases, an internet consumer guide,>

6. Title page, line 5, after <associations,> by inserting <special health and accident insurance coverages,>

7. Title page, line 9, after <applicable> by inserting <and including effective date provisions>

8. By renumbering as necessary.